Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

WORKER VERIFICATION FORM

RESET

Unit	Work Position
Claim number	
Date of request	
Date of injury	

Instructions to worker: This is your request for time-loss compensation. This must be completed before we can consider you for benefits. If you are unable to work due to your workplace injury AND your employer is not paying your wages: 1) Complete this form 2) Sign and date
3) Mail it to the address above within 14 days of the date you received this mailing.

Name	Phone number
Address	
City	State ZIP

Fill in ONLY if you have a new address and/or phone number.

Worker's Statement

I did not work, nor was I able to work, due to a work-related injury/illness from _____ to _____
(This means you did not perform **any** type of work – paid or unpaid – such as volunteer work, self-employment, COPES or CHORE Services. Please do NOT include the last date worked in the range above.)

I will/did return to work on _____	I am now working _____ Hours/Day	I am now working _ Days/Week	My current wage is: $_____ per ❒ Hour ❒ Day ❒ Week ❒ Month

I have applied for the following benefits: ❒ None ❒ Food stamps only ❒ Social Security benefits ❒ Unemployment ❒ Other public assistance programs

On the date of your injury, was your employer paying any part of your and/or your family's medical, dental and/or vision insurance benefits, or providing housing, board and/or fuel (utilities)? ❒ Yes ❒ No

Are you still receiving these benefits? ❒ Yes ❒ No, date coverage ended _____

By signing below, I am certifying the following: **I understand that if I make a false statement about my activities or physical condition, I will be required to refund my benefits and I may face civil or criminal penalties. I understand I must immediately contact my claim manager if I perform any work (paid or unpaid), if my doctor releases me for work, if I am incarcerated, or if the custody of my children changes.**

Phone #	Date	Worker's signature